Ruben King-Shaw, Jr.: Hello. I'm Ruben King-Shaw, Jr., Deputy Administrator and Chief Operating Officer for the Centers for Medicare & Medicaid Services. I'd like to welcome you to another in a series of broadcasts focusing on the Health Insurance Portability and Accountability Act, or HIPAA.

The Administrative Simplification Provisions of HIPAA require the adoption of industry-wide standards for electronic health care transactions. All health plans and clearinghouses, and all providers who conduct business electronically, must use these standards. These standards address the format, content, security and privacy of health care information transmitted electronically. The first of these standards, for transaction formats and code sets, was to go into effect in October of 2002. But the health care industry needed more time to build, test and successfully implement their systems. So President Bush signed into law a bill extending the effective date for compliance with those standards for providers who will not be compliant by that date. This will give the industry the time it needs to ensure the smooth execution of this first critical set of HIPAA standards, and all of us time to continue working actively toward HIPAA compliance.

In previous broadcasts, we've talked about how HIPAA will revolutionize health care electronic data interchange, and reduce costs, time and errors. I like to compare HIPAA to the changes we've seen in the banking industry over the past few years, and it's an analogy worth repeating. Think about it: we used to go to our local bank with passbook in hand to make deposits, withdrawals and conduct other business on our accounts. Today, we electronically access our accounts from home, a phone, virtually anywhere, and conduct all kinds of financial transactions, quickly, conveniently and securely. What made this possible is the banking industry's e-commerce platform that resulted in a home and community-based program that has changed the way we bank. This e-commerce platform has, in turn, had a positive effect on transportation, shipping, commerce, stock brokerage and a host of other industries. HIPAA, in essence, represents our commitment to build an e-commerce platform for health care that will move information, move money and enable health care services to be delivered through a similar home and community-based platform. This will free up funds currently directed towards administrative costs, and re-direct them to essential patient care services, an estimated $30 billion dollars in savings over ten years.

Today we'll focus on a very important step in the HIPAA Administrative Simplification process: the Compliance Plan. The law also requires that covered entities who will not be compliant with the HIPAA transaction and code set standards by October 16th, 2002 submit a compliance plan to get a one-year extension – to October 16th, 2003. The law also required the Secretary of Health and Human Services to provide a model form that you can use to request this extension. That form is now available, and during this broadcast you'll see what it looks like, how to complete it, and how to file it electronically to receive that extension. We'll talk about who is a covered entity and what that means to you as a provider. You'll see clips from the very successful CMS/SHARP conference in Atlanta, held earlier this year. You'll learn about where we are in our own testing process, and about some upcoming changes CMS resources such as frequently

asked questions or "FAQs", and our HIPAA mailbox that can help answer your questions. And finally, our panel of experts will discuss the questions that we are receiving on a wide range of HIPAA issues. As you listen, perhaps you'll find the answers to **your** HIPAA questions. These broadcasts are part of our continuing commitment to reach out to our provider community. That commitment includes an extensive program of national and regional provider outreach and education. I encourage you to visit our CMS website or contact your CMS regional office for additional assistance and resources.

We have a full program, so let's get started. On behalf of our Administrator Tom Scully, our CMS team and myself, thanks for joining us. We look forward to working with you.

Joe Broseker: Hello. I'm Joe Broseker, the Deputy Director for the Provider Billing and Education Group here at the Centers for Medicare and Medicaid Services or CMS. I'll be your guide today as we explore some of the challenges of implementing the Administrative Simplification portions of the Health Insurance Portability and Accountability Act of 1996 or HIPAA.

HIPAA is composed of five sections or titles. Today we will focus on the Administrative Simplification portion of title II. This requires the Secretary of HHS to adopt standards which define the format and content of the electronic transactions that are passed between health insurers and their trading partners. This is intended to reduce inefficiencies in the transmission of electronic information between health care providers, payers and clearinghouses. HIPAA seeks to simplify and encourage the electronic transfer of data by replacing the many different formats that are currently used with a single set of electronic standards that will be used throughout the health care industry.

Originally compliance with the electronic health care transactions and code set standards was required by October 16, 2002 but recently public law 107-105, the Administrative Simplification Compliance Act or ASCA, amended the HIPAA regulations and provided for a one year extension until October 16, 2003 if covered entities submit a compliance extension plan. Small health plans with revenues less than five million dollars have until October 16th, 2003 and do not need to submit an extension form.

But does this mean all provider organizations must begin transmitting claims in electronic format to all health plans on October 16th 2003? No, it does not. However, the new law does require the electronic submission of Medicare claims unless the Secretary grants a waiver.

So who is affected by the electronic standards mandated by HIPAA? The legislation is straightforward on this point. A covered entity is a health plan, a health care clearinghouse, or a health care provider who transmits any information in electronic form in connection with a transaction for which the Secretary of Health and Human Services has adopted standards. All covered entities must implement the new standards by October 16th, 2003.

Now lets hear from Elizabeth Holland, a member of the HIPAA Project Staff in our Office of Operations Management. Elizabeth will introduce us to some of the new CMS resources available on-line.

ELIZABETH HOLLAND: I'd like to share with you some of the HIPAA information that is available on our new web site. Our web site is located www.cms.hhs.gov/hipaa. Let's take a look. If you enter that web address it takes you to the HIPAA homepage. The top portion of the screen is devoted to Title I of HIPAA, the portability aspect. We will scroll down to HIPAA administrative simplification. We click on administrative simplification; it takes you to the administrative simplification homepage.

I'd like to point out a few things there. Notice this yellow box, this is where we will highlight new information on our web page, let's select it. This takes us to frequently asked questions on HIPAA administrative simplification. You can put in a word to search on, I will enter the word Form. This will bring up all of the questions that are related to our model compliance form. Let's select number two, where can I get a copy of the ASCA compliance form? Here you will see the question, the answer to the question, other related information. You can input an e-mail address that will let you know if the answer to this question is updated. You can rate the answer to this question so that we can improve our web site and you can also see other related answers.

Now let's return to the administrative simplification homepage. Under latest HIPAA administrative simplification news, we have our model compliance plan which we'll return to later, information on new regs that have been published, Health and Human Services HIPAA related links, which are a wealth of information, external HIPAA related links. We invite you to explore our web site. If you cannot find the answer to your question, we have an electronic mailbox where we will accept questions. Send your questions to: AskHIPAA@cms.hhs.gov and we will try to answer your questions.

However, we are unable to respond to privacy questions at this time as the privacy provisions at the HIPAA legislation are handled by our Office for Civil Rights in the Department of Health and Human Services.

Now let's take a look at the electronic health care transactions and code set standards model compliance plan. The electronic health care transaction and code set standards were finalized in August of 2000 and will go into effect October 16th, 2002. Small health plans have until October 16th, 2003. Many covered entities needed more time to become compliant which resulted in the Administration Simplification Compliance Act or ASCA becoming law. ASCA allows covered entities to request a one-year extension. To receive an extension, you must submit a compliance extension plan by October 15th, 2002.

We have supplied extensive instructions on our web site. We recommend that you read the instructions before you apply. You can submit a paper version of our model compliance plan by printing out the form or you can submit your own version of a

compliance that provides equivalent information. We will show the address to send your plans to at the end of this video. Please do not electronically submit and mail paper copies of the model compliance plan. One submission per covered entity either electronically or paper, will suffice. Also remember that CMS will not acknowledge receipt of paper submissions. For proof of delivery we suggest that you use the US Postal Service.

We recommend that you submit electronically so I will begin the electronic submission process. Here are the extensive instructions, read them thoroughly and then try to submit your plan. Today I'm going to proceed to the model compliance plan since I have read the instructions. The instructions also appear in the Federal Register, which was published on April 15th, 2002. You have two options for submitting your form electronically. You can use our secure server if you're browser supports it, if not, you can use the default, non-secure server.

Today I will use the default server. The form is very easy to complete. It consists of 26 questions, most of which are multiple choice. First you enter the name of the covered entity. Then you enter the covered entity's tax identification number, this is the IRS employer identification number. If there is no employer identification number, enter the covered entity's social security number. Then enter the Medicare identification number. If you are a Medicare physician, enter your U-pin number. If you are a physician group, enter your Medicare Group Identification Number. If you do not have a Medicare Group Identification Number, enter the tax identification number again. If you are not a Medicare provider, you do not need to enter any information in this field.

Next you select the type of covered entity. I am a physician, then you enter the authorized person and this is the person who can answer any questions we might have on this compliance plan. You enter the address for the authorized person, select the state, enter the zip code and the telephone number for the person. Click on continue and then it takes you to the next page. This is the reason for filing the extension and for me I need more money, but you can select all that apply, then your budget for implementing, you can select, and I will say, I don't know and then you select continue.

Then we proceed to a three-phased line of questioning. First, have you completed the awareness phase of the implementation process, I have, so I select yes and I scroll down to question 14. And I completed it in January of 1999. Then I proceed to Phase 2, Operational Assessment. I have to indicate whether I have completed the operational assessment and I will say yes and then I can proceed to Question Number 20 of when I completed this. And I will say I completed it in March of 2000.

Now there are questions about development and testing. Have I completed the testing phase and I will say no. Have I completed the software development, I've initiated but not completed. Have I completed staff training, initiated by not completed. The start date was, let's say February of 2000, the initial testing start date I can was April of 2000 and my projected completion date, let's say, is January of 2003 and that's why I need an extension. Now I review and submit and it allows me to review all the

information that I just entered.

If this information is correct, I select submit this plan electronically. This page indicates that my plan has been submitted to CMS and accepted. Before we leave this page, write down this confirmation number. You are now complete, however, if you do need to file for multiple entities that are included under the same implementation plan, I'll show you quickly how you can do that. You click on file for multiple entities and then what it does is it allows you to enter the first four fields again with your new information but all the rest of the information will be the same and you will click it on submit and then you'll get a new confirmation number for each additional entity that you submit.

Just remember if you are a covered entity other than a small health plan and do not submit a compliance plan, you must be compliant with the HIPAA electronic transaction and code set standards by October 16th, 2002. There are several other ASCA provision to remember. The Secretary of Health and Human Services can exclude non-compliant providers from participating in Medicare if they don't submit a compliance extension plan and are not compliant by October 16th, 2002. Effective October 2003 paper claims will not be paid by Medicare, there will be exceptions for small providers and under other circumstances, which we will be elaborating upon on a later date.

Be sure to check back over the next several months because we will be adding more and more information to our web site.

Thank you Elizabeth. Lets review: Determine if you need to submit a compliance extension form. If you are not certain if you will be compliant by October 16, 2002, we recommend that you submit a compliance extension form. The filing of a compliance plan should only take a couple of minutes. You should be concentrating your efforts on becoming compliant, not on filing out the form. Also to be safe, do not wait until October 15, 2002 to file your extension request electronically.

Now Rick Friedman, the Director of the Division of State Systems in our Center for Medicaid and State Operations. He's here to discuss the HIPAA checklist. But, one important point needs to be made. For this checklist to be most effective, begin to use it now if you have not yet done a HIPAA assessment for your organization. Don't wait until the last minute. Now, here's Rick

Rick Friedman: Hi. I want to talk today about a tool that we've found very helpful in looking at HIPAA compliance from the perspective of the people that are responsible for implementing solutions to HIPAA.

This is a tool that identifies ten different areas that we think are absolutely critical. It asks the person who is taking this tool to heart whether or not they've completed certain key steps by answering yes and no. Through these ten different areas one is able to get a very good picture of their degree of HIPAA compliance.

Let me show you the tool. To begin with it has ten different areas of risk. There's a HIPAA Project Office--questions about the budget, the resources, the contracts and plans. It then asks questions relative to the definition of whether or not you're a covered entity and your status in that regard; the coordination of your agency or your office or your department. It doesn't really matter where you sit in terms of an organizational structure.

This third section deals with coordination between yourself and others. The impact of HIPAA on your business processes, the systems impact assessment in which one would be through certain steps to see whether o r not your system is compliant, an overall design of the system and business processes changes that are affected by HIPAA; the degree to which you're able to renovate your system or systems completely; and then the validation that one has gone through in the testing procedures to make sure that you're HIPAA compliant.

Finally, when you go to implement the system and you go through a transition period what are the key areas that you want to pay attention to and finally contingency planning. Let's start with the first section, Part A which is the overall project office, the budgets and the resources.

You'll see that this Part A is comprised of different sub-sections. As one goes through this checklist the red bar which starts at the top of the section changes from red to yellow to green depending upon the number of yeses that you agree are actually the right answer for those different questions.

It's critical of course to have the right person answering this, and we would propose that it be the HIPAA project officer who has the best overall perspective. Has a HIPAA project office been established, yes or no? Yes. Does that project office have a written charter and a defined role? Yes.

Does the HIPAA project office support the highest level at the state? Yes. Is there a current work chart? Yes. Just to demonstrate how this tool works I will go through the rest of the questions answering yes to each of them. Are the HIPAA budget requirements known? Yes.

Are there needed advance planning documents or requests for funding? Yes. Is there resource planned? Yes. Are the staffing requirements assessed in the entire project? This is all front end planning relative to HIPAA contingency and HIPAA planning. Staffing resource is available. Does the HIPAA project office have a firm commitment of resources? Yes.

Are all necessary requests for proposals if you're getting a contractor onboard in place? Yes. Are contracts in place? Yes. Just click through a couple more of these to demonstrate how the red bar that was at the top of this has actually changed colors.

Let's go back up to the top and having answered most of the questions relative to the original stage you can see that it's now green. If instead you hadn't established a project office and

you changed these back to no you'll notice that the color has now turned from green to yellow.

If you were to answer more no's than I put in here where I had yeses you'll wind up with certain areas that are critical. These are weighted different ways in terms of what's important. We've now got enough no's in this section even though you'll see that there are other yeses in which the whole area has been painted red.

So it gives you a sense at least in this first stage relative to HIPAA project office budget's resources, contract and plans that some mixture of yes and no results in some sense of the degree to which in this particular area you would or would not really be compliant.

Not all the sections are a long as this first one. For example the second section dealing with the definition of covered entity status which basically define whether or not you need to be HIPAA compliant only has five key questions. If we go through this you'll see that the bar again changes colors depending upon the answer to the question.

This says has the Medicaid state agency defined its own covered entity boundaries. This is good not only for Medicaid state agencies but for any covered entity to ask yourself the question have you defined the boundaries. In this case we put yes.

Has any exempt component been identified? The answer to this case might be yes as well. Thirdly, does the organization that you're working for have any components which would qualify as being part of a covered entity? Yes. So we've gone from red to yellow with based on the number of yeses.

Does the Medicaid agency or the agency that you work for is the status of that understood relative to other state or other organizations that you deal with? Yes. We've now gotten enough yeses in this area to show that we're green. Does the project plan cover all of these different relationships?

Let's say the answer to that one is no. What it basically means is that four out of five are yes, and relative to the weights and the importance of all of these which lie beneath each question between a one, two and a three weight, it's--you wind up with a weighted average, and in this case we wound up with a green score.

If I could just turn to the results section of this we could go through more of the specific questions but you'll see those yourself. If you go to the results section this is a summary of each of those ten sections and it's color-coded based upon the scores that you put in, and it translates back to this.

There is also further up here a bar chart which shows that with part A this was the score, Part B that we went through which is green is an 80. We didn't answer the questions in Part C and D so they are red. It assumes that any area that you have not answered or addressed is inadequately responded to and therefore you wind up with a red color and a zero score.

But if you were to work your way through this compliance checklist you'd wind up then with a bar chart showing your score. Each of the areas would be color coded down here below. And for any area that's red and any area that's no we would recommend that you go back, analyze why there's a no and figure out what you need to do in order to address it.

When you wind up with all ten areas green through this self-assessment you'd have a very good sense and sense of confidence that indeed you would be HIPAA compliant.

Joe Broseker: Thank you Rick. Before we move on, I'd like to stress that all covered entities should begin their HIPAA assessment immediately, if you have not already done so. Janis Nero-Phillips, the Director of Division of Data Interchange Standards in our Office of Information Services, who will update you on where CMS and the Medicare contractor are with our own HIPAA testing.

Janis Nero-Phillips: In order to successfully test the HIPAA transactions with the thousands of Medicare trading partners, Medicare must first implement the HIPAA EDI transactions and certify that Medicare has met the requirements of HIPAA.

Medicare has taken advantage of the Administrative Simplification Compliance Act to extend our internal testing efforts prior to the operational use of the HIPAA EDI transactions. We anticipate that these testing efforts will make trading partner testing a positive experience.

Medicare has established three different types of testing for our systems:

1. Testing by the standard system maintainers
2. User testing by Medicare carriers and intermediaries in tandem with their translator and standard system and finally,
3. Certification testing following the seven levels of testing recommended by the Workgroup on Electronic Data Interchange and the Strategic National Implementation Process (WEDI/SNIP).

Collectively, there are seven levels of specific transaction testing which Medicare has adopted. The seven levels of testing include:

1. Integrity testing-This is testing for the valid segments, segment order, element attributes, numeric values in numeric data elements and the, X12 syntax, and compliance with the X12 rules.
2. Requirements testing-This is testing for implementation guide-specific requirements such as repeat counts and other required data element usage.
3. Balancing-This is testing for balanced field totals, record or segment counts, and financial balancing of summary fields.
4. Situation testing-Testing of specific inter-segment situation described in the implementation guides, including the validation of situational fields.
5. Code set testing-Testing for valid implementation guide-specific allowed code values.

6. Which is product types/types of service testing-particular testing for certain types of health care claims such as for ambulance, home health, durable medical equipment and certain other specialty claims. And finally,
7. Program testing-This is testing of the submitted data for compliance with certain Medicare program requirements.

Although not required by HIPAA, CMS has opted to require that each Medicare contractor become certified that they have properly implemented each HIPAA transaction. Certification testing offers the opportunity for uniform across the board testing of each contractor. CMS has selected an independent contractor to provide unbiased testing and certification services for both inbound and outbound HIPAA EDI transactions for the Medicare program. Our contractors are busy working through the certification process. As of May 2002, approximately 1/3 of Medicare contractors have received certification for the outbound HIPAA claim or the X12N 4010 837 transaction. Medicare contractor certification is progressing with other HIPAA transactions as well.

Providers should contact their respective contractor in order to obtain timeframes regarding submitter testing. Additional information can be obtained at the Medicare EDI web site, which is www.hcfa.gov/medicare/edi/edi.htm . Thank you.

Joe Broseker: Stanley Nachimson, a Senior Technical advisor on HIPAA with our Office of Operations Management, will now give you an update on the changes to the HIPAA administrative simplifications standards and process for requesting changes to the standards. These changes were published on May 31 and public comments must be submitted by June 30, 2002.

Stanley Nachimson: How do we make sure that the HIPAA standards stay up-to-date? We know that the needs of the health care industry change, as new types of organizations are formed and new types of treatment are developed. The standards need to be changed based on input from the health care industry.

To accomplish this, the Department has enlisted the aid of 6 organizations that have a history of developing health care transactions. These organizations, collectively known as Designated Standards Maintenance Organizations, DSMOs were named by the Secretary to receive requests for changes and recommend if those changes should be made.

These six organizations are:

The National Uniform Billing Committee, who has been responsible for the structure and content of the UB-92 institutional billing form;

The National Uniform Claim Committee, responsible for the structure and content of the CMS-1500 physician billing form;

The Dental Content Committee of the American Dental Association;

The National Council of Prescription Drug Programs, who developed the HIPAA standards for electronic transactions with retail pharmacies;

The X12 standards developing organization, that developed the HIPAA standards for all other provider;

And the HL7 standards developing organizations that has developed standards for clinical information.

These organizations represent a wide range of providers, health plans, vendors, and other participants in the health care industry. CMS and State Medicaid programs are active participants in these organizations.

To meet their responsibilities, the DSMOs have agreed to work collectively to update the HIPAA standards as necessary. They have established a web site (http://www.hipaa-dsmo.org) where anyone can request and justify a change to the adopted standards. The DSMOs will individually look at the request, and collectively determine if a change should be made. Recommended changes are presented to the National Committee on Vital and Health Statistics who will also review the changes. The committee will then present final recommendations to the Secretary of DHHS. It is then the Department's responsibility to publish these recommended changes first in proposed regulations to receive further public comment, and then in final regulations to make them an official part of the HIPAA standards.

The DSMOs have been actively receiving and reviewing requests for changes since October 2000, and their first set of recommended changes have been developed. We encourage you to submit any recommended changes to the standards to the DSMOs at their web site.

The initial HIPAA standards for transactions and code sets were published in regulations on August 17, 2000. These standards included a series of transactions developed by the National Council on Prescription Drug Programs for retail pharmacies to use, and transactions developed by the X12 standards setting organization for all other types of providers to use.

These standards had been part of our proposal published in 1998, and had been available for review since that time. We also spoke at numerous public forums about the standards, and placed articles in many industry publications. However, many covered entities, and other parties, did not review these standards until after the final rule was published. Upon review, many entities noticed that some of the standards would not allow them to do their processing appropriately, or would be very expensive to implement. There were also several technical errors in the initial regulation that needed to be corrected.

The biggest issue that was presented to the Department was the naming of the NDC code set as the sole code set to refer to drugs in all transactions. Many providers, especially hospitals, noted that the NDC code set was much too detailed for their business processes, would require major system overhauls, and would provide little benefit to them.

To resolve these issues, the Department will be publishing two proposed regulations in the very near future. The first proposed regulation will resolve the NDC code issue by retracting that code set as the HIPAA standard for everyone except retail pharmacies. All other types of providers will be able to use the HCPCS codes for drugs, as most currently do, along with the NDC code if necessary. The second proposed regulation will propose that corrections to the initial set of standards be adopted as HIPAA standards. These corrections, known as "addenda" to the initial set of adopted standards (known as HIPAA Implementation Guides) are a result of analyzing the request for changes submitted to the Designated Standards Maintenance Organizations. The DSMOs looked at the requested changes, determined which changes were critical to implementation, developed the addenda, and recommended that the Department adopt the addenda to revise the HIPAA standards.

These changes are not major changes to the standards, but rather improvements. Certain data elements have been removed, others have been changes from being required on every transaction to only being required in certain situations, and other date elements are now being included as part of some code sets.

These addenda are already available at the same web site as the initial HIPAA implementation guides - http://www.wpc-edi.com/hipaa.

What should you do? Review the addenda to assure that these changes are in accord with your needs. When the proposed rules, or NPRMs, are published; send in your comments to the Department. We will review and respond appropriately to any comment sent in to us.

Now, while we hope to publish these proposes rules soon, the changes we are proposing will not be made part of the HIPAA standards until after the October 16, 2002 compliance date. This means that any entity who wants to be compliant must use the initially published standards. If an entity wants to implement the suggested changes, they must file for the extension as they will not be compliant on October 16, 2002.

Joe Broseker: Several months ago, we attended the "Premier HIPAA Provider Conference" in Atlanta Georgia. The conference was the result of a successful collaborative partnership between CMS, the Southern HIPAA Administrative Regional Process or SHARP with cooperation from the Health Resources and Services Administration's Southeast Field Office. We spoke to many health care professionals about HIPAA. We thought it would be helpful to share some of their thoughts with you, although their inclusion in this video does not constitute approval or endorsement of their general policies or activities by CMS.

SHARP Conference

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We spoke to many healthcare professionals about HIPAA. WE thought it would be helpful to share some of their thoughts with you although their inclusion in this video does not constitute approval or endorsement of their general policies or activities by CMS.

Lucy Doyle: I wanted to tell you about a project called Aspire. For those who are dealing with the HIPAA 1500 paper form today there is a crosswalk from the 1500 to the 837. It is available to you. If you go to www.afehct.org and you'll see that it has worksheets, a read-me, a worksheet and a read-me.

What you need to do is pull out the read-me and print, and it's a word document. Then the other file is an Excel spreadsheet that takes you field-by-field cross walk from that 1500 form over to the 837. It's quite lengthy. It does take a lot of time to print it. But it's well worth your while if you want to understand exactly what the gaps are from the paper process to the 837.

It might help you in making decisions on how you want to deal with moving from paper to this particular transaction. I can't emphasize enough how valuable this information is. This is actually mentioned out there on the ASPE website that afehct (www.afehct.org) was doing this as a project. So hopefully you will go there.

One of the greatest challenges that we have is a re-engineering of all of our processes. From the paper to the electronic, everything that we do we need to take a look at. Make HIPAA your opportunity for improving your business practices.

Then you want to use electronic standards if you can. You want to look at your partnership relationships, your business associate agreements. You're gonna have some initial investments if you go to EDI, and they could be costly in the beginning. The cost savings comes after you had it implemented for a while.

So if you're looking for a return on investment you're looking at maybe a three-year program versus a one-year getting a return on your investment within a year. In some cases where you automate eligibility you can actually get a return on your investment within three months. So those are the types of things you will look at.

Jerry Williams, M.D.: The HIPAA regulations will permit physicians to enhance their billing and collecting by having one, one number and one form that is available for all third-party payers. It will also assist patients with the privacy piece. The protected health information will be just that--will be protected. It will permit patients to better

understand where their medical records are going and what portions of their medical records are being mailed.

So in my mind HIPAA is something that physicians need to be educated and need to understand. It's something that is going to happen. It is another regulatory cog to the wheel. But it's one that I feel over a period of time will help the physician in their practices.

There may be some up-front costs and there may be a little bit of a steep learning curve. But ultimately this will enhance the practice. It will reduce costs for the government. It will reduce costs in their offices. I believe it will be a very, very beneficial program for both patient and physician.

Elizabeth Wilkey: Really there are no shortcuts out there that a provider can take. I would say a provider should start testing early right now for Medicare, the party intermediary in the state of Georgia. We're already testing. We have vendors out there and we encourage those vendors and providers to test early.

Make sure that--if I was a provider I would make sure that my vendor could actually take my data and translate that data into an 837 format for claims submissions and that once that data is submitted to a payer that I could actually get that vendor to translate or remit back in the 835 format and upload it and post it to my account receivable system.

As for shortcuts, I've not seen of any shortcuts, but there are some vendors out there that can help a provider or help a vendor or clearing house be ready and test and become certified for HIPAA transactions, sets and standards.

We encourage the providers to go out on the websites. There's a wealth of information out there. The CMS website, of course the SHARP website. If you go out there you can actually get your employees trained on or you might call them your associates trained on HIPAA and the HIPAA guidelines and the HIPAA standards for the electronic transactions.

Providers should also realize that the electronic transactions are not the only standards that their internal staffs need to be educated on. They also need to know about privacy and security. All three of these things working together is what's gonna make a provider really be compliant for HIPAA.

Joe Broseker: For those in other parts of the country viewing the broadcast today how would you advise them if they wanted to start down this path to form something like Sharp? How would you advise them to go about doing that and what would you say the benefits would be?

Sue Miller: Well, first they could go out in the WEDI/SNIP website where Sharp and a bunch of other regional efforts who are already listed and they can talk to the regional efforts that have begun and are further along the road than they are in implementation or beginning in an organization such as Sharp.

There are also national assets within WEDI/SNIP who will come and help any state or group of states or group of people who are interested in starting an outreach effort, which will help across the industry in the local area. I think some of the benefits are that you already know each other. You're already working together to do other chores, and you're going to continue to learn from each other.

But you have established somewhat of a relationship of trust and working already. And, you're going to understand additionally the needs of your environment, which potentially would be different than the national environment and any other regional efforts. So I think there are twofold again--that you know each other already and that you're going to know the problems that you are finding that are different than other regions.

Rhonda M. Meadows, M.D.: Florida Medicaid is doing what all health plans have to do to address HIPAA. We've done our need assessments of all of our services and functions. We've actually consulted with an outside group to come in and help us learn where are needs are in areas that we haven't thought of in the past.

We're educating our staff. We have several meetings over a series of time to get them used to each of the different components of administrative simplification. I would suggest physicians and all providers actually look forward to the benefits they'll reap at the end of this process.

They'll be able to enjoy a time where there'll be a universal forum and system in place for them to be reimbursed for the hard work they've done from a multitude of different payers, plans and insurance companies. They'll be able to serve Medicaid and Medicare, the patients which really need them in the same manner with the same tools and same systems.

I think it's important that healthcare providers, physicians, health plans all realize the important role that they have in HIPAA being implemented and being implemented for the benefit of patients. Everyone has to understand that once this system is in place things will go much smoothly so that the focus can be on the quality of healthcare given and not on the quality of paperwork that has to be generated.

Joe Broseker: Now let’s join our panel of experts who will discuss some of the questions that we have been receiving on HIPAA Administrative Simplification.

Panel Discussion

Joe Broseker, Moderator

Hello, I'm Joe Broseker, Deputy Director of the Provider Billing and Education Group at the Centers for Medicare and Medicaid Services. I'm here today with several HIPAA specialists to discuss HIPAA implementation issues and answer some of the questions we've received from physicians, providers, health plans and clearinghouses.

Before we start, let me introduce you to our panel. Stanley Nachimson, Senior Technical Advisor on the HIPAA project staff in our Office of Operations Management, Rick Friedman, Director of the Division of State Systems in the Center for Medicaid and State Operations, Janis Nero-Phillips, Director of the Division of Data Interchange Standards in our Office of Information Services, and Elizabeth Holland, technical advisor on the HIPAA project staff in our Office of Operations Management.

Joe Broseker: Today we have talked about the Administrative Simplification Compliance Act that provides for a one-year extension to the date of compliance with the Final Electronic Health Care Transactions and Code Sets standards. Specifically, covered entities, except small health plans, that submit a compliance extension plan by October 15, 2002 will get an additional year, until October 16, 2003, to come into compliance. Elizabeth, can you review how to apply for an extension?

Elizabeth Holland: Certainly Joe, there are several ways to apply for an extension. We recommend applying electronically via our web site which is located at www.cms.hhs.gov/hipaa. We will show the website address at the end of this program. If you file electronically, you will receive a confirmation number which lets you know that your plan has been received and accepted. If you cannot submit your compliance plan electronically via our website, or you want to submit your own version of a compliance plan that provides equivalent information, it can be printed and mailed to us. We will show the address at the end of this program. Just remember that we cannot acknowledge receipt of paper submissions. So for proof of delivery, we suggest that you use the U.S. Postal Service.

Joe Broseker: Now Elizabeth, I have heard that you have been getting many questions about filing for an extension. Can you tell us of any tips for those filing electronically?

Elizabeth Holland: Sure. First, read the instructions to see if you need to file for an extension before you try to fill out the form on-line. If you are sure that you will not be compliant by October 16, 2002, then file for an extension. The instructions will tell you what information you'll need to have to complete the form. The form is easy to complete. When you submit your plan electronically, you will receive a confirmation number. Be sure to write it down. Do not spend too much time completing the form. It should only take about 15 minutes. Instead focus your time and energy on doing what it will take to become compliant. Finally, do not wait until October 15, 2002 to file electronically.

Joe Broseker: Janis, can you give us a quick status on the steps Medicare is taking to implement the EDI transactions and code sets?

Janis Nero-Phillips: Okay Joe, you may be aware that Medicare is a health plan and is subject to the requirements set forth by HIPAA. In order for Medicare to properly implement HIPAA, Medicare has opted to file for an extension that will require Medicare to fully implement the various electronic health care transactions by October 16, 2003. Medicare has taken full advantage of the administrative simplification

compliance act to extend our internal testing efforts prior to the operational use of the transactions. So, over the past several months the Medicare contractors and standard systems maintainers have been working diligently to both test and implement the HIPAA transactions.

Joe Broseker: Thanks Janis. What's involved in this testing process.

Janis Nero-Phillips: Several things are involved Joe. Testing of the transactions has been established to detect errors and inconsistencies within and among our standard systems and at the contractor sites. Medicare is in the process of testing for potential system errors and is working to correct them prior to widespread testing with providers and other submitters. We are working through the seven levels of testing established by the industry. In addition, Medicare is using a certification company who acts as a neutral third party to validate and each contractor we want to make sure has met the requirements for each individual transaction. Let me point out that this certification is not a HIPAA requirement. However, if each Medicare contractor can achieve certification, the likelihood of successful
interaction among HIPAA trading partners should increase significantly.

Joe Broseker: How soon can providers and other submitters begin to test transactions with their respective Medicare contractors?

Janis Nero-Phillips: Some submitter testing is going on right at this moment. A small number of providers are already testing. We expect to be ready for widespread testing of most of the transactions by the summer of 2002. We suggest that each provider contact their respective Medicare fiscal intermediary or carrier to obtain specific directions about the testing protocol procedures and timeframes. Once a provider completes a successful test for a transaction with Medicare, they will be able to move directly into production.

Joe Broseker: Now how will we know that Medicare will be HIPAA compliant on October 16, 2003 and will be ready to process these transitions correctly?

Janis Nero-Phillips: Over the past several months we have made significant progress with the implementation of the majority of the HIPAA EDI transactions. We expect to be ready well before October 16, 2003 so we can give providers the opportunity to test and CMS has made arrangements for each contractor to become certified by the independent certification company. Please note that certification for Medicare again or any other entity is not required by HIPAA. However, certification testing offers Medicare the opportunity to create uniformity among the contractors. So it really is incumbent upon all the trading partners to adequately test the various transactions with their respective contractors.

Joe Broseker: Thank you Janis for some excellent advise with regards to testing with providers. Now let's turn to Stanley now. Stanley, earlier in the program there was a

discussion regarding the addenda. Can you tell us a little bit more about the changes in the addenda? How significant are they?

Stanley Nachimson: Sure Joe. And these are changes to the initial set of standards that we published in August of 2000. What we did was take a look at all of the changes that were requested by the industry since the standards were initially published, used the DSMOs and picked out the changes that were absolutely necessary for covered entities in order for them to use the standards successfully and make those changes to the standards.

These are changes that are basic improvements to the standards. They make certain data elements situational rather than required in all cases, and they change some data elements from required data elements to those included in certain code sets.

Joe Broseker: Thank you. Can I use the addenda now?

Stanley Nachimson: As a matter of fact you can. The addenda as we mentioned before are available at the website where all of the implementation guides are published. However, covered entities need to remember that if they use the addenda now these are not the official HIPAA standards.

If they chose to use the addenda they must apply for the extension that we've already talked about.

Joe Broseker: What if someone doesn't like the addenda?

Stanley Nachimson: Covered entities and basically anyone will have the opportunity to comment on the addenda. We will be publishing a proposed rule that proposes that these addenda become part of the official HIPAA standards. When that rule is published the public will have the opportunity to send in comments to the department on the addenda and let us know if these changes that we are proposing are the right changes to be made in the standards.

Joe Broseker: Thank you. Now what if I need more changes to the standards beyond the addenda?

Stanley Nachimson: If there are changes that anybody wants to make in the standards the department as we've mentioned before has arranged with a set of organizations called Designated Standards Maintenance Organizations to receive requests for changes to the standards, evaluate those requests and advise the department whether or not those changes should be made.

So anyone will have the opportunity and does have the opportunity to let the DSMOs know that a change should be made in the standard.

Joe Broseker: Could you refresh us as to why the department picked these DSMOs?

Stanley Nachimson: Certain Joe. These DSMOs, the Designated Standards Maintenance Organizations, are organizations that have historically been involved in determining what types of information should be included in healthcare transactions and how that information should be passed between providers and health plans.

These organizations have the technical knowledge to advise the department about these standard transactions, and they represent a wide variety of participants in the healthcare industry.

Joe Broseker: Thanks a lot Stanley.

Stanley Nachimson: You're welcome.

Joe Broseker: Now, Rick. Let's talk to you about Medicaid. Can you tell us just where the states are. Will they be ready to implement HIPAA?

Rick Friedman: Yeah, I think that's a good question Joe. A lot of people are asking the same question. We believe that all the states will be compliant with the deadline and be ready to implement HIPAA on time. We don't anticipate any problems.

Joe Broseker: Okay. Will the states be filing for the extension?

Rick Friedman: Yes. We think that most states will be filing for the extension. Even those that anticipate actually being ready earlier than the deadline date will probably file a protective filing just to make sure they had adequate time in order to do all the testing that's necessary.

Part of being HIPAA compliant means that it's important not only that you're own system is compliant but that those that you trade with and the provider community and the rest. So just as Janice mentioned it's important that the entire enterprise be HIPAA compliant, and it's critical that the testing take place. For that reason states will be filing for extensions.

Joe Broseker: Thanks Rick. Now it sounds like the states are doing a lot of things. Can you tell us some of the steps the states are taking to get ready?

Rick Friedman: Sure. The states like everybody else have analyzed their current systems, try to do a gap analysis relative to the what the requirements actually are. Then they've gone through the process of remediating or renovating their systems.

That's all relevant to their own systems, but states are also looking at testing and implementation activities associated with HIPAA compliance because as I said earlier it's important that not only their systems be HIPAA compliant but those that they trade with are.

Joe Broseker: Okay. Now have the states been working together on HIPAA or have they been pretty much going off on their own.

Rick Friedman: It's a good question. The states are working together on HIPAA. Y2K was really the first opportunity that states had to look at a common IT problem and begin to identify solutions across the country which they thought would probably be helpful in their own situation.

HIPAA is the same sort of action forcing event. The states have had to make a number of changes relative to what they've been used to doing in terms of their local code sets and a variety of other things. So they've gotten together over the past three years. They've worked very hard in committees at a national level to resolve these issues and they've done both internal remediation and testing as I mentioned earlier as well as working with these national groups.

Joe Broseker: Okay. Thanks Rick. Now I understand that you've been busy, your office has been busy, helping the states and others. Can you tell us what CMS has done to make being HIPAA compliant easier for not only the states but information that also might be useful for others such as providers, other payers and so forth.

Rick Friedman: Sure. Unlike Medicare, which CMS directly operates, the states actually operate the systems associated with paying claims for Medicaid. So it is at the state level where this action is taking place. Our role at CMS is to try to identify best practices, solutions around the country that a variety of states have come up with which will help one another. So we've been doing this sort of information exchange.

In addition to that we help pay for these changes to a large degree in which we're matching the costs of these changes up to as high as 90% of the cost. So that even if the states are experiencing budget difficulties as one hears in today's papers, in terms of HIPAA the federal government is helping to support the costs of these changes associated with HIPAA.

In addition it's important that providers are also HIPAA compliant, and we're making sure that the states on their own are reaching out to the provider community, to clearing houses and to translators and to everybody across the board in order to work together on this.

States are the best people to contact in terms of Medicaid. They all have HIPAA websites for the state. We at CMS have identified individuals in the states who are the HIPAA Medicaid leads. If you turn to our website here at CMS that Elizabeth mentioned earlier you'll see in the Medicaid HIPAA section something called a Medicaid HIPAA compliant concept model.

If you turn to that you'll see inside a tool kit which identifies a variety of things which we think are really useful not only to the states but to the providers in the community. This includes a variety of white papers that we've had experts develop over time; contacts with associations that states rely on for communicating and sharing information; as well as something called a HIPAA Compliant Risk Assessment.

Joe Broseker: Thank you very much to all of our panel members today. On a final note, several provisions of the HIPAA legislation remain in the proposal stage and have not yet been published as final rules. So it's important that you regularly monitor the status of regulatory activity.

CMS will be updating its website regularly. The Medlearn page on the CMS website is the place to find out about this and other Medicare learning network products.

Once again, I'm Joe Broseker and on behalf of Stanley Nachimson, Rick Friedman, Janis Nero-Phillips, and Elizabeth Holland, and the entire CMS team, thank you for joining us.

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The Centers for Medicare and Medicaid Services

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Special Thanks To:
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Elizabeth Wilkey
Rhonda M. Meadows, M.D.
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2002

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